2024 Summary of Benefits

January 1, 2024 – December 31, 2024

WellSense Added Value (HMO)

H6851-001

WellSense HEALTH PLAN

Summary of Benefits

WellSense Added Value (HMO) is an HMO plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

The benefit information provided does not list every service we cover or list every limitation or exclusion. To get a complete list of services we cover, call us at 800-967-4497 (TTY users should call 711) and ask for the Evidence of Coverage. You can also see our Evidence of Coverage at our website, **wellsense.org/medicare.**

To join WellSense Added Value (HMO) you must have both Medicare Part A and Part B, and live in our service area. Our service area includes all counties in New Hampshire.

Except in emergent, urgent care situations, or other situations as described in our Evidence of Coverage, if you use a non-contracted, out-of-network provider, we may not pay for these services.

For coverage and costs of Original Medicare, you can read the "Medicare & You" handbook. You can view it online at **Medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as braille, large print, or other alternate formats at no cost if you need it.

For more information, please call us at:

- Current members: **855-833-8128**
- Prospective members: **800-967-4497**
- TTY users: **711**
- Hours are Monday – Friday, 8:00 a.m. – 8:00 p.m. (Representatives are available 7 days a week, 8:00 a.m. – 8:00 p.m. from October 1 – March 31)

You can also visit our website at **wellsense.org/medicare** for more information.

WellSense Added Value (HMO) Summary of Benefits

Services that are covered for you	What you must pay when you get these services
Premium and Benefits	
Monthly Plan Premium	$36.00 per month (Your premium could be less if you qualify for "Extra Help". Please see our *Evidence of Coverage*, Chapter 2, Section 7 for more information.) You must continue to pay your Medicare Part B premium.
Deductible	Part B Deductible (In 2024, the Part B Deductible is $240.)
Maximum Out-of-Pocket Responsibility (Does not include Part D prescription drugs or supplemental benefits)	You pay no more than $8,850 annually for services you receive from in-network providers. Includes copayments and other costs for medical services for the year (does **not** include supplemental benefit cost-sharing). If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services, and we will pay the full cost for the rest of the year.
Inpatient Hospital Care *Prior authorization is required.*	$565 copay each day for days 1 – 4 of each hospital stay.

Services that are covered for you	What you must pay when you get these services
Outpatient Hospital Services, including outpatient observation *Prior authorization may be required.*	Part B deductible and 20% coinsurance
Ambulatory Surgical Services (Day Surgery, Surgical Day Care, Surgi-Centers, Ambulatory Surgical Centers) *Prior authorization may be required.*	Part B deductible and 20% coinsurance
Doctor's Office Visits – Primary Care Providers (PCP) or Specialist These visits may be available in-person or by telehealth. There is no cost-sharing for the "Welcome to Medicare" physical or annual wellness visit. *Prior authorization may be required for some services.*	Part B deductible and 20% coinsurance

Services that are covered for you	What you must pay when you get these services
Preventive Care Coverage is provided for the following Medicare-covered preventive services: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screening • HIV screening • Immunizations, including flu shots, hepatitis B shots, pneumonia shots • Medical nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Welcome to Medicare preventive visit (one-time) • Other preventive services are available and may have a cost and/or may be subject to prior authorization such as a CT scan for Lung Cancer Screening	There is no coinsurance, copayment or deductible applied to this benefit by the Plan.

Services that are covered for you	What you must pay when you get these services
Emergency Care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. Coverage is limited to services provided in the U.S. and its territories.	$100 copay per visit Cost-sharing for necessary emergency services furnished out-of-network is the same as services furnished in-network. If you are admitted to the hospital within 24 hours of discharge from the emergency room, this cost-sharing will be waived.
Urgent Care Services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Coverage is limited to services provided in the U.S. and its territories.	$55 copay per visit Cost-sharing for necessary urgent care services furnished out-of-network is the same as services furnished in-network. If you are admitted to the hospital within 24 hours of discharge from an urgent care center, this cost-sharing will be waived.

Services that are covered for you	What you must pay when you get these services
Diagnostic Services, Labs, Therapeutic Services/Supplies, and Imaging Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used • Other outpatient diagnostic tests *Prior authorization may be required for some services, including but not limited to genetic testing, CT Scans, MRIs, PET/Nuclear Medicine, Intensity Modulated Radiation Therapy and other select services. Prior authorization does not apply to x-ray services.*	Part B deductible and 20% coinsurance Outpatient laboratory services: $0 copay
Hearing Services, Medicare-covered Coverage is provided for diagnostic Medicare-covered hearing and balance evaluations to determine if you need medical treatment.	Part B deductible and 20% coinsurance for each covered hearing exam to determine if you need medical treatment for a hearing condition. **Additional hearing services** Routine hearing exam (1 every year): $0 copay

Services that are covered for you	What you must pay when you get these services
Dental Services Covered services include: • Medicare-covered dental services • Preventive Care, including up to 2 visits per year (exam, X-rays, cleaning) • Comprehensive Dental Care, including extractions, restorative care, endodontic care, periodontic care, crowns (limitations apply) and dentures.	Medicare-covered dental services: Part B deductible and 20% coinsurance **Additional dental services** Preventive Dental: $0 copay Comprehensive Dental: 0% coinsurance up to a maximum of $1,500 paid by the Plan per calendar year.
Vision Services Covered services include: • Medicare-covered vision services, including: o A yearly glaucoma screening and diabetic eye exam o Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration o One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens	Medicare-covered eyewear: $0 copay All other Medicare-covered services: Part B deductible and 20% coinsurance **Additional vision services** Routine vision exam (1 per year): $0 copay $300 allowance every year toward the purchase of one pair of eyeglasses, contact lenses or hardware upgrades

Services that are covered for you	What you must pay when you get these services
Mental Health Care **Inpatient:** There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health Services provided in a psychiatric unit of a general hospital. **Outpatient:** Services include, but are not limited to: individual and group counseling, psychotherapy, and psychological testing. *Prior authorization is required for inpatient mental health services and outpatient psychiatric services, this includes transcranial magnetic stimulation (TMS) and Applied Behavioral Analysis (ABA).*	**Inpatient**: $385 copay each day for days 1 – 5 of each hospital stay **Outpatient**: Part B deductible and 20% coinsurance
Skilled Nursing Facility Care (SNF) Coverage is provided for up to 100 medically necessary days per benefit period. Prior hospital stay is not required. A benefit period begins on the first day a member is admitted to a skilled nursing facility and ends when the member has been out of a skilled nursing facility for 60 consecutive days. There may be more than one benefit period per year. *Prior authorization is required.*	$0 copay per day for days 1 – 20 $203 copay per day for days 21-100

Services that are covered for you	What you must pay when you get these services
Outpatient Rehabilitation Services Coverage is provided for physical, occupational, and speech language therapy. *Prior authorization is required but is waived for the initial evaluation for each therapy.*	Part B deductible and 20% coinsurance
Ambulance *Prior authorization may be required for non-emergency ambulance transportation.*	Part B deductible and 20% coinsurance
Transportation	Not covered
Additional Benefits	
Substance Use Services **Inpatient**: Coverage is provided for substance use services, including detoxification. **Outpatient**: Coverage is provided for individual and group therapy visits.	**Inpatient**: $565 copay for days 1-4 of each hospital stay **Outpatient**: Part B deductible and 20% coinsurance
Opioid Treatment Program Services	$50 copay per visit
Foot Care Coverage is provided for Medicare-covered podiatry services. *Prior authorization may be required.*	Part B deductible and 20% coinsurance
Durable Medical Equipment (DME) Coverage is provided for Medicare-covered Durable Medical Equipment including but not limited to wheelchairs, oxygen, etc. *Prior authorization is required for DME that costs $500 or more.*	20% coinsurance

Services that are covered for you	What you must pay when you get these services
Prosthetic Devices Coverage is provided for Medicare-covered prosthetic devices, including but not limited to braces, artificial limbs, etc. *Prior authorization is required.*	20% coinsurance
Diabetes Supplies and Services Coverage is provided for Medicare-covered diabetes supplies and services, including but not limited to: • Blood glucose meter • Blood glucose test strips • Lancing devices and glucose lancets • Syringes and pen needles • Glucose control solutions for checking the accuracy of test strips, glucose meters and glucose monitors *Prior authorization is required for select diabetes supplies and for diabetes supplies and services that cost $500 or more.*	Part B deductible and 20% coinsurance
Over-the-Counter (OTC) items Coverage is provided for Medicare-covered services and supplies available over-the-counter at a pharmacy or contracted retailer. • $245 per calendar quarter. Any unused amounts will not be rolled-over to the next calendar quarter within the same calendar year.	There is no coinsurance, copayment or deductible applied to this benefit.

Services that are covered for you	What you must pay when you get these services
Fitness Benefit - SilverSneakers® SilverSneakers® is a complete health and fitness program designed for Medicare beneficiaries at all fitness levels. Members will have access to participating gyms and fitness centers to help them meet their personal wellness goals. Please note nonstandard fitness centers that usually have an extra fee are not included in your membership.	There is no coinsurance, copayment or deductible applied to this benefit.
Chiropractic Care Coverage is provided only for manual manipulation of the spine to correct subluxation.	Part B deductible and 20% coinsurance
Nursing Hotline	There is no coinsurance, copayment or deductible applied to this benefit.
Home Health Care *Prior authorization is required.*	There is no coinsurance, copayment or deductible applied to this benefit.
Renal Dialysis Coverage is provided for Medicare-covered dialysis equipment and supplies.	Part B deductible and 20% coinsurance
Hospice Care Coverage is provided by Original Medicare when you enroll in a Medicare-certified hospice program. Your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare.	There is no coinsurance, copayment or deductible applied to this benefit by the Plan.

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Home Meals Program Coverage is provided for home delivered meals to a member's residence, in the following situations: • Immediately following an inpatient acute care setting – up to a maximum of 28 meals • Request must be within 30 days of discharge	There is no coinsurance, copayment or deductible applied to this benefit.
Prescription Drug Benefits	
Medicare Part B Drugs (including Insulin Drugs) Some drugs are covered by Medicare Part B and some are covered by Medicare Part D. Part B drugs do not count toward your Part D initial coverage limit or out-of-pocket costs. This plan offers step therapy from one Part B drug to another Part B drug. *Prior authorization may be required for some drugs, including Insulin drugs.*	Part B deductible and 20% coinsurance Insulin drugs are subject to a $35 copayment for a 30-day supply.
Deductible Before the Part D plan starts to pay for any of your Part D medications, you must pay your annual deductible.	$545 Applies to Tier 1 drugs
Initial Coverage After you pay your yearly deductible, you pay the coinsurance listed until your drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and the Part D plan.	25% coinsurance up to a maximum of $5,030

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Coverage Gap Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay 25% of the plan's cost for covered generic and brand name drugs until your costs total $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.	25% coinsurance up to a maximum of $8,000 (combined with what the member and the Plan pays)
Catastrophic Coverage After your yearly out-of-pocket drug costs reach $8,000, you will pay the amount(s) listed.	$0